Notice of Accidental Dismemberment and Loss of Sight Claim

Clear Form

Minnesota Life Insurance Company, a Securian Financial Group affiliate
Group Division Claims • P.O. Box 64114 • St. Paul, MN 55164-0114

For claim information call:
Toll free 1-888-658-0193
Fax 651-665-7106

MINNESOTA LIFE

PART 1 - TO BE COMPLETED BY EMPLOYER

1. Policyholder's name | 2. Policy number

3. Employee date of birth (month, day, year) | 4. Date employed (month, day, year) | 5. Salary $ Per ☐ Hour ☐ Week ☐ Month

6. Job title | 7. Date last actively worked

8. Status on last day worked ☐ Full time ☐ Part time If part-time, average hours per week. _____

Amount of Employee's Insurance
Basic $ _____
Optional $ _____

Effective Date of Coverage
_____
_____

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

Name of employer | Employer's telephone number

Employer's address

Authorized signature
X

Date

PART 2 - CLAIMANT'S STATEMENT -

To present your claim for benefits, complete this Claimant's Statement. All questions must be fully completed. Have your physician complete the Attending Physician's Statement and attach copies of your medical records. **Please be sure to sign and date the authorization.**

1. Claimant's legal name (last, first, middle initial) | 2. Date of birth (mo/day/yr) | 3. Social Security number

4. Address (Street, City, State, Zip) | 5. Telephone number

6. Date accident occurred | 7. Where accident occurred

8. Did the accident result in dismemberment or total and irrecoverable loss of sight? ☐ Yes ☐ No

9. Please fully describe the accident.

10. If the dismemberment, total and irrevocable loss of sight occurred on a date later than the date of the accident, please list that date.

11. Name and address of physician treating you | 12. Telephone number

13. Name and address of hospital | 14. Telephone number

For the purpose of determining my eligibility for insurance coverage and benefits, I authorize any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge, including but not limited to my physical or mental health or financial information or employment, to give all such information it has to **Minnesota Life Insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any medical or health history including all consultations, diagnoses, prescriptions, treatments, tests, as well as any information regarding alcohol or drug abuse, AIDS or AIDS-related conditions.

I authorize the Company to release any information relevant to my insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom I have coverage, or to any other public or private entity as may be required.

This authorization shall be valid for 24 months from the date it is signed. I have read it and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time except to the extent that Minnesota Life has taken action in reliance upon the authorization prior to notice of revocation. Revocation of this authorization by me in writing shall be effective upon receipt by Minnesota Life.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

Signature of insured
X

Date signed

PART 3 - ATTENDING PHYSICIAN'S STATEMENT

HISTORY

1. Patient's name	2. Patient's date of birth
3. Date accident occurred	4. Date amputation or loss of sight occurred

5. Location of accident (work, etc.) Describe:

6. Has patient ever had same or similar condition or prior disabilities? ☐ Yes ☐ No

7. At the time of the accident, amputation, or loss of sight, was the patient receiving care or treatment of any disease or illness? ☐ Yes ☐ No

8. Was the patient's dismemberment, total and irrevocable loss of sight caused (directly or indirectly) by any physical or mental infirmity; illness or disease; self-inflicted injury: commission of a felony; drugs or poison taken voluntarily; bacterial infection; travel on any military aircraft; or war? ☐ Yes ☐ No

If answers to any of the above questions "yes", describe particulars in detail, including dates.

DISMEMBERMENT

9. Was there an amputation resulting in severance through or above the wrist or ankle joint? If "yes", give complete description of dismemberment. ☐ Yes ☐ No

TOTAL AND IRREVOCABLE LOSS OF SIGHT

10. Did total and irrecoverable loss of sight occur as a result of the accident? ☐ Yes ☐ No

11. Did total and irrecoverable loss of sight occur more than 90 days after the accident? ☐ Yes ☐ No

WHAT WAS VISION AT LAST OBSERVATION? (SNELLEN NOTATION)

12. With glasses	O.D.	O.S.	Date
13. Without glasses	O.D.	O.S.	Date

DATE CORRECTED VISION WAS IRRECOVERABLY REDUCED TO 20/200 OR LESS IN THE BETTER EYE

14. Month/day/year

☐ O.D. ☐ O.S.

Vision can be restored in whole or part by:

15. O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

16. O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

Please enclose copies of any visual fields testing that has been done.

PLEASE INCLUDE COPIES OF YOUR MEDICAL RECORDS PERTAINING TO THE LOSS

17. Name of attending physician (please print)	18. Degree	19. Telephone number

20. Physician's address (street, city, state, zip)

Signature of attending physician	Date signed	Print name of person completing this form
X		

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